Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCUS P HAYES
PO BOX 198
BARKER, TX 77413-0198

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-12-3505-01

MFDR Date Received

AUGUST 01, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached you will find a copy of the EOB received, a copy of the electronic billing information, a copy of the original claim form submitted stamped "request for reconsideration", a copy of the original claim form submitted, and a copy of the documentation supporting the following performed on [injured worker] on 05/09/2012:

1. Maximum Medical Improvement (MMI) & Impairment Rating Determination (IR) for the compensable injury, CPT Code 99456-WP, 1 unit.
2. Extent of Injury Determination, CPT Code 99456-W6, 1 unit

According to the EOB received, payment was denied due to;

(16) – Claim/service lacks information which is needed for adjudication

(4) – The procedure code is inconsistent with the modifier used or a required modifier is missing."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After manually reviewing the claim for Dr. Marcus Hayes our Litigation department has found the following: Charges were correctly disallowed requesting corrected billing for further review. Per Texas Fee Schedule (http://www.tdi.texas.gov/wc/rules/documents/134.pdf §134.204. Medical Fee Guideline for Workers' Compensation Specific Services (i;1;C). (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6;" (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursed shall be $500 in accordance with subsection (i) of this section and shall include Division required reports. Testing that is required shall be billed using the appropriate CPT Code codes and reimbursed in addition to the examination fee."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due

May 09, 2012	CPT Code 99456-WP and 99456-W6	$950.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 12, 2012

   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 16 – Claim/service lacks information which is needed for adjudication

   Explanation of benefits dated July 18, 2012

   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 16 – Claim/service lacks information which is needed for adjudication

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-WP for one unit in the amount of $650.00 and 99456-W6 for one unit in the amount of $300.00 for Maximum Medical Improvement (MMI)/ Impairment Rating (IR) and Return to Work (RTW).

   Review of the submitted documentation supports a Report of Medical Evaluation (DWC-69) that an examination was performed to address Maximum Medical Improvement (MMI)/Impairment Rating (IR) with one body area using range of motion and Return to Work (RTW).

   Per Administrative Code §134.204 (i) The following shall apply to Designated Doctor Examinations, (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350, (4) The following applies for billing and reimbursement of an IR evaluation, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows, (I) spine and pelvis, (II) upper extremities and hands; and (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (II) If full physical evaluation, with range of motion, is performed, (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.

   CPT Code 99456-WP is supported. The Total Mar for CPT Code 99456-WP is $650.00.

   Per Administrative Code §134.204 (i) The following shall apply to Designated Doctor Examinations and (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

CPT Code 99456-W6 is not supported. Therefore, CPT Code 99456-W6 no reimbursement allowed.

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $650.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		8/13/13
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.